MEDICAID ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE PROGRAM AUDIT REPORT APPEAL REQUEST

Submit completed form to: EHR_audit_appeals@hhsc.state.tx.us

SECTION 1: ELIGIBLE PROFESSIONAL (EP) CONTACT INFORMATION

Section 1 – Provide the following information regarding the EP who is filing an appeal request for the Medicaid EHR Incentive Program (fields marked with * are required). The contact information provided below will be used to communicate with the EP during the appeal. It is the EP's responsibility to notify the Texas Health and Human Services Commission (HHSC) of any changes to this information. If multiple EPs are appealing for the same practice address and will use the same contact information, please fill out one form and attach a list of names, National Provider Identifiers (NPIs), and Program Year of all appealing EPs.

First Name*	Middle Initial	Last Name*	Credentials (i.e., M.D., D.O.)
Individual National Provider Identifier (NPI) (10 digits)* (Do not include a Group NPI)			

Practice Address Line 1 (Street Name and Number – Not a Post Office Box)*		
Practice Address Line 2 (Suite, Room, etc.)		
City/Town*	State* (2 character code)	Zip Code (5 digits)*
Email Address* (This is how HHSC will communicate with the EP regarding the appeal.)		
Business Telephone Number (Include Area Code)*	Extension	

What Program Year Audit are you appealing?*	☐ 2011 ☐ 2012 ☐ 2013 ☐ 2014 ☐ 2015

SECTION 2: AUTHORIZED REPRESENTATIVE CONTACT INFORMATION

Section 2 – If the EP is designating a third party to represent him or her in this appeal, please provide the information below for the authorized representative working on behalf of the EP. If multiple EPs are appealing from the same practice under Section 1 and will use the same third party representative, HHSC will designate the authorized representative listed here for each appealing EP. If a contact person is listed below, all correspondence related to this appeal will be sent to the e-mail and mailing address listed in Section 2 as well as Section 1 above.

First Name	Middle Initial	Last Name	Suffix (i.e. Jr., Sr.)
Entity/Organization Name			
Address Line 1 (Street Name and Number – Not a Post Office Box)			
Address Line 2 (Suite, Room, etc.)			
City/Town	State (2 character code)	Zip Code (5 digits)	
Email Address			
Business Telephone Number (Include Area Code)		Extension	

SECTION 3: APPEAL SUBMISSION INSTRUCTIONS

What Audit Report are you appealing? *	☐ Draft Audit Report - **See Section 3.1** ☐ Final Audit Report - **See Section 3.2**

All Section 3 requirements must be submitted to HHSC at: EHR_audit_appeals@hhsc.state.tx.us

Section 3.1 - Draft Audit Report Appeal - In addition to this completed form, to submit an appeal of a Draft Audit Report, please attach only a written memorandum that includes within it the following appeal information:

1.) Draft Audit Report detailed finding(s) being appealed (cite number of the deficiency/finding from the Audit Report)
2.) Explanation of why, according to the EP, the audit finding(s) is/are incorrect.

The memorandum must not exceed 10 pages (one sided) using a font no smaller than 12 point. Any additional documentation submitted beyond what is requested above will not be reviewed or considered during the appeal.

Section 3.2 - Final Audit Report Appeal - To appeal a Final Audit Report, this completed form must be submitted to the email address indicated in this section above. No additional documentation should be submitted at this time. HHSC will email a confirmation receipt and provide additional instructions regarding the Final Audit Report appeal criteria and process.

SECTION 4: CERTIFICATION STATEMENT - APPEAL REQUEST

Section 4- Read the information and certification statement below and confirm the following:

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

It is the responsibility of the EP or the EP's authorized representative to submit an appeal prior to the 30 day deadline by completing an Audit Report Appeal Request Form. Per Section 3.1, Draft Audit Report appeal requests must be submitted with an EP memorandum attached. As detailed in Section 3.2, only the completed Audit Report Appeal Request Form is needed to request a Final Audit Report appeal. HHSC will issue further instructions relating to the Final Audit Report appeal upon receipt of this form.

If an HHSC receipt confirmation email is not received by the EP or his or her authorized representative within three business days following submission of this form to HHSC, it is the responsibility of the EP or the authorized representative to ensure the documentation was received prior to any deadlines.

All appeal-related documents from HHSC will be delivered via two methods to the EP or the EP's authorized representative, if applicable, as follows: email (primary method) and United States Postal Service certified mail (secondary method).

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I certify that the foregoing information is true, accurate, and complete. I understand that this Medicaid EHR Incentive Program appeal may result in a final determination in which the EP must refund an overpayment of incentive funds to HHSC, including recoupment through Medicaid claims payments.
AUTHORIZED REPRESENTATIVE WORKING ON BEHALF OF AN EP:
I certify that I am submitting this request for an appeal on behalf of an EP who has given me authority to act as his or her agent. I understand that both the EP and I will be held responsible for all information submitted.

By confirming this certification statement, I agree to the foregoing statement, and it is my intent, to sign this request for an appeal.

☐ **Confirm***

Date (mm/dd/yyyy)*:

Print name of EP or EP authorized representative*:

Signature of EP or EP authorized representative*:

DO NOT WRITE BELOW THIS LINE